STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-Compliance Revisit.	{F 000}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 33 residents and 5 residents sampled for review and 3 residents sampled for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure 2 of the 3 sampled residents who had pressure ulcers received the necessary treatment and services to prevent new ulcers from developing (failure to reposition in 2 hours, failure to provide a pressure relieving device in a wheelchair, failure to monitor daily the resident's pressure ulcers, and failure to measure weekly the size of the pressure ulcers). . (Resident #27 and #18) Findings included: - Resident #27's 9/20/13 physician's orders included diagnoses of Alzheimer's disease	{F 314}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 1	{F 314}		

(progressive mental deterioration characterized by confusion and memory failure).

Resident #27's 10/9/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident short and long term memory problems, moderately impaired decision making skills, and fluctuating disorganized thinking. The resident needed total assistance of two staff for bed mobility and transfers and total assistance of 1 staff with toilet use. According to a formal assessment, the resident posed a risk to develop pressure ulcer with a stage 2 pressure ulcer that started 10/3/13. The pressure ulcer presented with granulation tissue. The resident also presented with a surgical wound and a skin tear. Interventions to treat/prevent the pressure ulcer included pressure relieving devices in his/her bed and chair, a turning/repositioning program, a nutritional/hydration program, and pressure ulcer care.

Resident #27's 10/9/13 Pressure Ulcer CAA (Care Area Assessment) summary reported that the resident had a 0.2 cm (centimeter) red, stage 2 pressure ulcer to both of his/her buttocks with a physician's order to treat the pressure ulcer with an ointment. The CAA reported the resident recently fractured (broken bone) his/her left hip, required total assistance with all his/her cares, and often refused to be repositioned in bed.

Resident #27's 10/18/13 Norton Scale scored the resident as a "15", indicating the resident posed a high risk to develop pressure ulcers.

Resident #27's care plan, last reviewed on 10/16/13, informed staff that the resident had cognitive problems and needed assistance of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 2	{F 314}		

staff for all his/her cares since he/she broke his/her left hip. The care plan indicated the resident posed a risk of developing a pressure ulcer but failed to mention if the resident had any pressure ulcers. Interventions included instructions to licensed nursing staff to assess the resident's skin weekly, notify the resident's physician of any problems, and to keep a pressure relieving device in his/her chair. On 10/9/13, two handwritten revisions instructed staff to change his/her position at least every 2 hours for pressure relief and to encourage the resident to change position while in bed at night while using pillows to support proper body alignment. On 10/22/13, staff revised the care plan to float the resident's heels.

Review of resident #27's nurses' notes revealed the resident transferred to a local acute hospital on 10/8/13 and returned to the facility on 10/18/13. A 10/18/13 nurse's note documented that the resident presented with a small pressure ulcer on the right buttock that lacked mention of size or stage, a 1 cm blister on his/her left heel, and an unmeasured/unstaged "red area" on the lateral (outer) side of his/her left foot. The nurse's note documented that the resident had a "theraboot" (a device to float the heel) on his/her left foot and that his/her family and physician received notification about the new pressure ulcers.

A "Licensed Nurse Weekly Skin Assessment" form, dated 10/19/13, documented the resident had:
* 2 cm (without indication of length or width) "red shearing area" to middle left buttock
* 3 cm (without indication of length, width, or depth) "round, red, stage 2 in the center of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 3	{F 314}		

shearing" on the middle right buttock
* 1 cm by 0.5 cm "red area" on the lateral right foot (though the 10/18/13 nursing note documented this area on the left foot)
* 1.5 cm by 1 cm "blister area" on the right heel (though the 10/18/13 nursing note documented this pressure ulcer on the left heel)
* documented that the resident had reddened areas that remained after 30 minutes of pressure reduction but lacked mention of the location

Review of the resident's clinical record lacked daily documentation of the conditions of each pressure ulcer on 10/20/13 and 10/21/13.

A "Weekly Skin Sheet", dated 10/22/13, lacked mention of the condition of the resident's right and left buttocks. The form reported pressure ulcers on resident #27's left foot:
* 2 cm by 2.5 cm blister on the left plantar (sole) of the foot under the smallest toe that lacked mention of staging
* 2.5 cm by 2.5 cm stage 1 pressure ulcer on the lateral left foot
* 2.5 cm by 2.5 cm "boggy" (soft, fluid filled) blister on the left heel
* 0.6 cm (without mention of length or width) greenish/tan blister also on the left heel

A 10/22/13 nurse's note reported that the physician received notification that the theraboot caused the left foot pressure ulcers and that nursing staff informed physical therapy about the pressure ulcers. Nursing staff received orders to stop using the theraboot and apply lotion to both the resident's feet.

Review of the resident's clinical record lacked daily monitoring of the condition of the pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 4	{F 314}		

ulcers on 10/23/13 and 10/24/13.

A 10/25/13 nurse's note reported "blister continued below little toe" but lacked documentation of 3 other pressure ulcers on the left foot or the condition of the resident's right and left buttocks.

A "CNA (certified nursing assistant) weekly skin assessment on bath day" form, dated 10/26/13, reported that the resident had no open areas. The form had a signature from a CNA and a licensed nurse.

A 10/27/13 nurse's note reported "pillows under both lower extremities (limbs) to float heels. Both blisters intact with skin hardened over the blister on the left heel. Reddened areas to lateral aspect of left foot healed. Lotion applied to both lower extremities". The nurse's note lacked documentation of the condition of the pressure ulcer on the sole of the foot or the condition of the resident's right or left buttocks.

Review of the clinical record lacked daily documentation of the conditions of each pressure ulcer on 10/28/13.

A 10/29/13 nurse's note reported "blister dry and split, left open to air" but lacked mention of which blister or the condition of the other pressure ulcers.

A 10/30/13 nurse's note on a "Skin/Wound Care Charting" form reported "no change" but lacked mention which skin issue it referred to.

A 10/31/13 nurse's note reported that physical therapy received a physician's order to evaluate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 5	{F 314}		

and treat the resident's left foot blister "below the little toe" but lacked mention of physical therapy orders for the pressure ulcers on the left heel.

A 10/31/13 physical therapy evaluation of the left plantar pressure ulcer documented that the blister appeared covered with dried, tan eschar (dead tissue). Treatment included cleaning the area with normal saline, debridement (removal of the dead tissue), and covering the wound with "medihoney" and a 2 cm x 2 cm "covaderm" (a type of dressing). The wound measured 2 cm by 0.8 cm with no depth and after debridement the wound appeared red and moist without exudate (thick drainage that is a sign of infection). The physical therapy note reported a plan to see the resident 5 times a week for debridement and dressing changes. Review of the clinical record lacked mention of the condition of the resident's pressure ulcers on his/her left heel or right/left buttocks on 10/31/13.

A 11/1/13 physical therapy note reported that they debrided the left plantar pressure ulcer and redressed the wound with "medihoney" and a 2 cm by 2 cm "covaderm". The note reported the wound appeared "good" with red tissue and the dead tissue came off without need of an sharp instrument.

A 11/1/13 nurse's note reported "the resident's left foot continues the same" but lacked mention of the condition of the resident's right/left buttocks.

A 11/2/13 nurse's note reported the dressing the left plantar area remained dry and intact and that staff floated his/her heels. The note lacked mention of the condition of the resident's left heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 6	{F 314}		

pressure ulcers or the condition of the right/left buttocks.

The clinical record lacked documentation from physical therapy on 11/2/13 or 11/3/13.

A 11/3/13 nurse's note reported "feet are dry lotion applied" but lacked documentation of the condition of the dressing on the left plantar or the condition of the left heel pressure ulcers or right/left buttocks.

A 11/4/13 physical therapy note reported they debrided the left plantar pressure ulcer with scissors, the wound appeared red with granulation (new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process) tissue, and redressed the wound with "remedy skin repair cream". Review of the clinical record lacked evidence that staff monitored the condition of the pressure ulcers on the left heel or the condition of the right/left buttocks.

During an observation on 10/5/13 at 7:30 a.m., 7:50 a.m., 8:13 a.m., 8:39 a.m., 8:45 a.m., 9:00 a.m., 9:17 a.m., 9:33 a.m., 9:48 a.m., 9:55 a.m., and 10:06 a.m. , resident #27 sat in a wheelchair without a pressure relieving device in the seat and without the benefit of a position change as directed by the care plan (a time period of 2 hours and 36 minutes). At 10:06 a.m., licensed nursing staff C informed direct care staff F to reposition resident #27. An inspection of the resident's buttock area revealed no skin breakdown and no redness. The resident had a 0.5 cm by 0.5 cm bright red, intact, non-blanchable (to press blood away and wait for return to determine blood circulation) pressure ulcer on the lateral side of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 7	{F 314}		

his/her right foot, a 2 cm by 3 cm scabbed dried blister on his/her right heel, and a 2 cm by 2 cm bright red, intact, non-blanchable pressure ulcer on the sole of his/her right foot below his/her smallest toe.

During an interview on 11/5/13 at 12:03 p.m., direct care staff F reported that resident #27 had a pressure relieving device in an older wheelchair but had not had one since using a new wheelchair. Staff F reported he/she lacked knowledge that resident #27 ' s care plan directed staff to reposition the resident every two hours and stated he/she thought staff should reposition the resident every three hours. "

During an interview on 11/5/13 at 2:44 p.m., licensed nursing staff C reported that staff should reposition resident #27 every 2 hours and he/she should have a pressure relieving pad on the seat of his/her wheelchair.

During an interview on 11/6/13 at 9:40 a.m., staff C reported that nursing staff should evaluate the condition of resident's pressure ulcers on a daily basis and measure the pressure ulcers weekly, such as resident #27. He/she verified that resident #27's clinical record did not consistently have daily documentation or weekly measurements of his/her pressure ulcers.

During an interview on 11/6/13 at 11:41 a.m., administrative nursing staff A reported that the facility expected nursing staff to reposition every resident, including resident #27, at least every 2 hours and that every resident, including resident #27 should have a pressure relieving device in their wheelchairs. He/she reported that nursing should measure the resident's pressure ulcer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 8	{F 314}		

weekly until physical therapy began, and then physical therapy held the responsibility to measure the pressure ulcers weekly. At approximately 2:00 p.m., staff A verified the clinical record lacked consistent daily monitoring of the resident's pressure ulcers or weekly measurements prior to physical therapy's evaluation on 10/31/13.

The facility's "Wound Care" policy, revised in October 2013, instructed that CNA's will inspect the resident's skin with each bath and report abnormalities to the nurse. The nurses will complete a "total skin observation form as scheduled" but lacked instruction of specifics about the schedule. All residents identified as "at risk" for skin breakdown will have pressure relieving cushions in their wheelchairs and/or recliners. Repositioning of residents who could not reposition themselves should occur every 2 hours. Instructions related to assessing a wound included monitoring the size and staging of pressure ulcers but lacked instructions about how often the measurements or documentation of monitoring should take place.

The facility failed to provide resident #27 the necessary treatment and services to promote healing and prevent new pressure ulcers from forming (failure to reposition in 2 hours, failure to provide a pressure relieving device in his/her wheelchair, failure to monitor daily the resident's two left heel pressure ulcers and pressure ulcers on the right/left buttocks, and failure to measure weekly the size of the pressure ulcers prior to physical therapy treatment on 10/31/13).

- Resident #18's 9/21/13 physician's orders included diagnoses of neuropathy (damage or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 9	{F 314}		

disease involving nerves, which may affect sensation, movement, gland or organ function and other aspects of health), congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and dementia (progressive mental disorder characterized by failing memory, confusion).

Resident #18's 9/4/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident had short and long term memory problems, moderately impaired decision making skills, and fluctuating disorganized thinking. The resident required extensive assistance of one staff for bed mobility and total assistance of 2 staff for toileting and transfers. According to a formal assessment tool, the resident had a risk of developing pressure ulcers but had no pressure ulcers present during the observation period. Interventions to prevent development of a pressure ulcer included a pressure relieving device in his/her chair and bed and application of ointment.

Resident #18's 3/18/13 Pressure Ulcer CAA (Care Area Assessment) summary reported the resident had diagnoses of dementia and congestive heart failure and depended on staff for mobility out of his/her wheelchair/recliner/bed. The CAA reported the resident had a pressure relieving pad in his/her wheelchair and recliner and had no pressure ulcers at the time of the observation.

Resident #18's care plan, last reviewed on 9/11/13, instructed staff to monitor the resident for skin breakdown. The resident posed a risk of developing pressure ulcers due to dependence on staff for toileting and position changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 10	{F 314}		

because of dementia and loss of mobility. Interventions included changing the resident's position every 2 hours, keep a pressure relieving device in his/her chair, and for CNAs (certified nursing assistants) to report any skin issues to the nurse while monitoring his/her skin during baths. The care plan also instructed staff to place barrier cream on his/her buttock after each toileting and/or incontinence episode. On 10/14/13, staff revised the care plan that the resident had a stage 2 pressure ulcer on his/her coccyx (tailbone) and to continue with the previous skin treatment.

Review of the resident's 10/11/13 nurses' notes revealed that resident presented with a new 0.8 cm (centimeter) by 0.8 cm open area on his/her coccyx. The nurse's note indicated the area as a "small opening, round, red, possibly caused by sheering, no drainage, no odor, surrounding skin no redness". Nursing staff notified the physician and received an order to apply zinc cream to the area daily. Nursing staff notified the resident's family about the wound and treatment order. The nurse's note lacked mention of the stage of the pressure ulcer.

A 10/12/13 "CNA weekly skin assessment on bath day" form indicated the resident had no open areas on his/her skin. The form had a signature of a CNA and licensed nurse.

Resident #18's clinical record lacked evidence of daily monitoring of the coccyx pressure ulcer on 10/13/13.

A 10/14/13 nurse's note reported the physician ordered to consult with physical therapy about an evaluation and treatment for the coccyx pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 11	{F 314}		

ulcer. The nurse's note indicated that physical therapy ordered to cover the pressure ulcer with a "polynem" dressing, to keep the pressure ulcer clean, and keep the resident off of his/her bottom as much as possible.

Review of the clinical record lacked documentation of the condition of the coccyx pressure ulcer on 10/14/13 and 10/15/13.

A 10/16/13 "CNA weekly skin assessment on bath day" form indicated the resident had an open area on the coccyx but lacked mention of the wound's condition.

A 10/17/13 nursing note reported the resident's coccyx pressure ulcer measured 1 cm by 1 cm and reported it as "open" but lacked mention of a stage.

Resident #18's clinical record lacked evidence of daily monitoring of the condition of the pressure ulcer 10/18/13.

Resident #18's 10/19/13 "Licensed Nurse Skin Weekly Assessment" form reported the resident had an open area on the coccyx.

Resident #18's clinical record lacked evidence of daily monitoring of the condition of the pressure ulcer from 10/20/13 to 10/25/13.

Resident #18's "weekly skin assessment on bath day" forms on 10/26/13 reported the resident had an open area on the coccyx.

Resident #18's clinical record lacked evidence of daily monitoring of the condition of the pressure ulcer from 10/27/13 to 10/29/13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 12	{F 314}		

Resident #18's "weekly skin assessment on bath day" forms on 10/30/13 reported the resident had an open area on the coccyx.

Resident #18's clinical record lacked evidence of daily monitoring of the condition of the pressure ulcer 10/31/13 to 11/4/13.

Review of resident #18's clinical record lacked evidence of measurements of the coccyx pressure ulcer between 10/18/13 and 11/4/13 (a time period of 18 days).

During an observation on 11/5/13 at 11:06 a.m., licensed nursing staff E measured the pressure ulcer on the resident's coccyx which presented as a 1 cm linear slit along the buttock crease and had a red wound bed. The surrounding skin and the skin of both buttocks appeared bright red and blanchable (to press blood away and wait for return to determine blood circulation).

During an observation on 11/5/13 at 2:25 p.m., 2:39 p.m., 2:45 p.m., 3:01 p.m., 3:15 p.m., 3:31 p.m., 3:46 p.m., 4:00 p.m., 4:12 p.m., 4:34 p.m., 4:45 p.m., and 4:58 p.m., the resident laid on his/her back with his/her legs bent and feet laying on each left side without a benefit of a position change (a total of 2 hours and 33 minutes). Upon request at 4:55 p.m., licensed nursing staff D informed direct care staff H to reposition the resident.

During an interview on 11/5/13 at 5:21 p.m., direct care staff H reported that resident #18 should be repositioned every 2 hours.

During an interview on 11/5/13 at 4:55 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 13	{F 314}		

licensed nursing staff D reported that the facility expected staff to reposition resident #18 at least every 2 hours.

During an interview on 11/6/13 at 1:58 p.m. licensed nursing staff E verified that nursing staff did not consistently chart daily about the condition of the resident's pressure ulcer as they should nor take measurements weekly as the facility expected.

During an interview on 11/6/13 at 11:41 a.m., administrative nursing staff A that the facility expected nursing staff to reposition every resident, including resident #18, at least every 2 hours. He/she reported that nursing staff should measure the resident's pressure ulcer weekly. At approximately 2:00 p.m., staff A verified the clinical record lacked consistent daily monitoring of the resident's pressure ulcers or weekly measurements.

The facility's "Wound Care" policy, revised in October 2013, instructed that CNA's will inspect the resident's skin with each bath and report abnormalities to the nurse. The nurses will complete a "total skin observation form as scheduled" but lacked instruction of specifics about the schedule. All residents identified as "at risk" for skin breakdown will have pressure relieving cushions in their wheelchairs and/or recliners. Repositioning of residents who could not reposition themselves should occur every 2 hours. Instructions related to assessing a wound included monitoring the size and staging of pressure ulcers but lacked instructions about how often the measurements or documentation of monitoring should take place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 14 The facility failed to provide resident #18 the necessary treatment and services to promote healing and prevent new pressure ulcers from forming (failure to reposition in 2 hours, failure to monitor daily the resident's coccyx pressure ulcer, and failure to consistently measure weekly the size of the pressure ulcer).	{F 314}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 15 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 33 residents. Based on observation, interview and record review, the facility failed to maintain medications according to professional standards when staff failed to destroy insulin for resident #18 within 28 days of opening as recommended by the drug manufacturer. Findings included: - During an observation on 11/4/13 at 2:29 p.m., the facility medication room contained medications used for facility residents. The medications included a Humalog insulin prefilled pen for resident #18. According to a date on the pen, staff opened the pen on 10/3/13, 32 days earlier. According to the website www.humalog.com <http://www.humalog.com>, " Once opened, Humalog vials, prefilled pens and cartridges should be thrown away after 28 days. " During an interview on 11/4/13 at 3:30 p.m., Licensed Nurse B reported staff should remove the opened pens from circulation after 28 days. Nurse B also reported the facility expected licensed nurses to check the dates and dispose of expired medications on a daily basis.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 16 The facility ' s undated " Medication Storage " policy did not address staff removal of expired medications from circulation such as the Humalog insulin. The facility failed to store medications according to professional standards when staff failed to discard an open container of Humalog insulin after 28 days as per the manufacturer ' s recommendations.	{F 431}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 17 This REQUIREMENT is not met as evidenced by: The facility reported a census of 33 residents. Based on observation, interview, and record review, the facility failed to develop and implement an effective system to ensure that action plans were developed through the Quality Assessment and Assurance (QAA) program related to monitoring and treatment/prevention of pressure ulcers and failure to dispose of expired insulin pens. Findings included: - During an interview on 11/6/13 at 2:06 p.m., administrative nursing staff A reported that on 9/24/13, the facility's QAA committee met to discuss the results of the 9/6/13 annual resurvey and to develop action plans to correct the deficiencies written. Staff A reported those in attendance included the medical director, the dietary manager, the housekeeping manager, the maintenance supervisor, and him/herself. - Based on observation, interview and record review during the noncompliance revisit, the facility failed to ensure 2 of the 3 sampled residents who had pressure ulcers received the necessary treatment and services to prevent new ulcers from developing (failure to reposition in 2 hours, failure to provide a pressure relieving device in a wheelchair, failure to monitor daily the resident's pressure ulcers, and failure to measure weekly the size of the pressure ulcers) as cited at F 314. - Based on observation, interview and record	{F 520}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	R 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 18 review during the noncompliance revisit, the facility failed to to maintain medications according to professional standards when staff failed to destroy insulin within 28 days of opening as recommended by the drug manufacturer as cited at F 431. The facility failed to develop and implement an effective system to ensure that action plans were developed through the Quality Assessment and Assurance (QAA) program related to monitoring and treatment/prevention of pressure ulcers and failure to dispose of expired insulin pens.	{F 520}		